

recommendation of the Maryland Chapter Study published in 1950 called for the establishment of a blue-ribbon permanent state planning group for facilities and services for children with handicaps of all kinds, with pediatrics contributing its share of leadership, and made it possible to establish the two interprofessional clinics for children having developmental aberration, including retardation, one at each University pediatric department.

I hope that pediatricians will find out what is going on in their own state in terms of comprehensive planning for the retarded and see to it that the pediatric point of view has

adequate representation. The pediatrician is after all the first one to see the child after birth and is in the best position to make an early diagnosis and provide health supervision and ongoing total child care. This is an important pediatric area, and a copy of the supplemental Report of the Task Force on Prevention, Clinical Services and Residential Care will provide a host of ideas about working with the state planning groups.\*

\*A copy of this report can be obtained from Edward Davens, MD, Chairman, Committee on the Handicapped Child, American Academy of Pediatrics, Room 1302, 301 W Preston St, Baltimore, Md 21201.

## Social and Psychological Aspects of the Panel Report

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It has been very interesting for me to see that, without consultation, the members of the Panel have all come up with the same feeling about what was accomplished, what the process was in evolving the report and carrying out the work. As Dr. Thelander indicated, before the President's Panel came into being, most of us were quite complacent about working with bits and pieces of service separated from each other and very often operating in vacuums. But the Panel was given a mandate to pull together these bits and pieces from every discipline which could make a contribution to a plan that would cover the entire field of mental retardation. Out of their thinking came a picture of how one can function on an over-all coordinated basis. The mandate included the necessity for thinking boldly and broadly; without such thinking it would be very difficult to deal with this problem in the country as a whole. We are almost forced to think in these terms: from a practical point of view, if our states do not think comprehensively

they cannot qualify for the monies that are being made available by the Congress for planning and programs.

We have evidence from other countries, particularly the Scandinavian countries and a few others, that there can be a significant reduction in the rate of mental retardation through the application of currently known facts and the provision of the appropriate services. We already have the knowledge for implementation, but we do not know what to do with our old established bits and pieces of service. We are in the situation in which the Australian Bushman found himself when he was given a new boomerang; he could not get rid of his old one.

I would like to turn for a few minutes to the assignment I was given to talk about the social and psychological aspects of the field of retardation as they were dealt with by the Panel. First of all, there is the broad question of maternal and child health care, which is recognized as a key component. We became concerned not about the mothers who could come to our prenatal clinics or who could carry out participation in the programs

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for pediatric care, but with those who could not. For example, we know in the District of Columbia how many babies are born in the large municipal hospital and we know how many babies get to well-baby clinics; fully a third of them are never heard from again until the law says the children have to appear in school. They will turn up very often without vaccination, other immunizations, or health care of any kind. We have to abandon, at least to some extent, our traditional concepts of sitting in one place and expecting all our patients to come to us. We have to set up services that can reach out—setting up prenatal clinics in those shopping centers which might be located in low-income areas, having a bookmobile type of well-baby clinic, and so on. These are the kinds of things we will have to think about if we are going to get to the core of the problems which produce the largest segment of our retarded children.

It becomes apparent that we have to reach the large group of children in whom cultural deprivation is the basis for the retardation as early as possible. The experience of child development specialists is that most of these children start out with normal potentials in infancy, and in working with such children one sees that the retardation is present only in the areas we know about measuring. In what we have come to call "survival intelligence" these are usually very bright children; they know how to keep their heads above water, but not in school. But adequate academic performance is extremely important in today's world.

Day-care centers are one approach to the problem of providing adequate stimulation. Originally legislation was written for such centers starting at 3 because enough is known about what kinds of programs to start at 3 years of age. Age 3 to 5 years certainly is not too late; but sometimes we see that by 3 there are already well-defined characteristics that we would regard as pathological. Realizing how much cognitive and personality development occurs in the first 3 years, the panel members felt it was important to think

of setting up infant day-care centers also. When we were asked, "What do we do with the babies in these infant centers?" we had to say, "We do not know." We have some guidelines from what is going on in other countries—the programs in Russia and Israel, and more recently in Scandinavia and France, and currently now in England. We know that the traditional institutions for infants are harmful, and the only thing we can suggest at the moment is foster day-care for infants. Unfortunately we know from experience that our programs as currently constituted are also not adequate enough. However, research has already begun on finding answers that it will be possible to use in such programs, hopefully in the not too distant future.

I would like to stress an axiom that has been emphasized in the work of the panel: that every child has a right to a normal personality as well as a right to as normal as possible a physical existence. It is possible and necessary to make this available for the retarded child; even those with more severe dysfunction can, within their limitations, have a normal personality. Furthermore, there should be the right to have an assessment of what is wrong, and the right to have everything available done about it. In addition, if we are to provide all kinds of services—educational, remedial, and so on—we need to have a child who is accessible for teaching, one who is not suspicious of people, or autistic and living in another world. These are some concerns that we have to keep in mind as we set up our over-all programs.

Retardation is a problem that faces not only us in pediatrics but the country as a whole. There has been awareness lately that a significant segment of the unemployed falls into the retarded category. It becomes obvious that there has not been the planning from childhood which is necessary for the useful incorporation of the majority of the retarded into our labor force, or for making it possible for the majority of retarded individuals to function outside of a protected setting.

One word regarding the danger of dichotomies and jurisdictional disputes in planning programs in mental retardation. There is no real reason for the jurisdictional disputes except in terms of the ways in which segments of the programs are funded. If there is one person who is important throughout the whole life experience of a child who is retarded, it is the pediatrician; he is one of the common denominators. Another is the psychiatrist, a third the neurologist. The need in the child's experience for the pedi-

atrician or the psychiatrist or any other specialist, medical or nonmedical, can be fairly well spelled out. Just as the psychiatrist needs to sit down and work out definitions of his place in the field of mental retardation, the pediatrician too can work out a definite picture of what his responsibility is at such phase of a child's development in relation to mental retardation. When these are matched with each other, we will see that there is no dichotomy but indeed a need to work together.

## Mental Retardation and Abnormal Human Development

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There are two features of the Panel report about which I wish to speak. One aspect is a matter of definition of terms, which has far reaching implications. The other is the practical operational consideration of how to get an important job done well, quickly.

First, there seems to be continuing confusion over the relationship between mental retardation and abnormal human development. Stated as clearly as possible, it is my view that mental retardation is simply one form of abnormal human development. It is obviously not the only form of abnormal human development, but it is certainly an important one in terms of frequency in the population and resistance to present forms of therapy. In fact, we do not know the specific cause of mental retardation in roughly 80% of those youngsters institutionalized in high quality residential facilities. The causes which are known range from genetically controlled molecular diseases to gross anatomical changes in the central nervous system. There is also an important portion of the mentally retarded who may have acquired significant disability in intellectual functioning as the result of behavioral and social factors.

Director, National Institute of Child Health and Human Development (Dr. Aldrich).

In order to learn about abnormal intellectual development, we must understand what is normal. We have only part of this essential knowledge at this time, and, if I may sound an alarm among the fraternity, I would like to draw attention to the inescapable fact that research and training for work on normal and abnormal development in the social and behavioral fields are not primarily in the hands or minds of pediatricians.

We must recognize that the job is so important and so pressing that bright minds from many disciplines are moving in to help. They are *welcome* and they must be fully utilized in this prime area of research. But the pediatrician cannot hang back and avoid his or her obligation to learn about the social and behavioral sciences, as well as those related to prenatal life. A new direction of training is at hand and should be grasped on a grand scale. Classical pediatric training must be extended and broadened if we are to maintain leadership in child health and human development.

Mental retardation is after all a disorder of normal development which usually has its origin in prenatal life, but whose effects extend for a full life span. The manifestations of mental retardation are postnatal and are measured in decades. I know of no better